LAWRENCE COUNTY CAREER AND TECHNICAL CENTER
750 Phelps Way, New Castle, PA 16101-5099 ♦ 724-658-3583 Fax 724-658-4753 ♦ www.lcvt.tec.pa.us

LCCTC EMERGENCY/CONSENT FORM

Student's Name: _____ Grade/Shop: _____
Last First Middle

Address: _____
Number Street City/PO Box Zip Code

Student's Home Phone#: _____ Birthdate: _____ Male:_____ Female: _____
Included Area Code

Home School District: _____ Student Lives with: _____

Father/Guardian Name: _____ Home#: _____ Cell#: _____

Employer: _____ Work Time: _____ Work#: _____ E-mail: _____

Mother/Guardian Name: _____ Home#: _____ Cell#: _____

Employer: _____ Work Time: _____ Work#: _____ E-mail: _____

THE WEL-BEING OF ANY STUDENT IS A PARENTAL RESPONSIBILITY. EVERY EFFORT WILL BE MADE TO CONTACT THE PARENT DURING A STUDENT ILLNESS, INJURY, OR EMERGENCY. WHEN UNAVAILABLE, PLEASE LIST TWO ADULTS WHO COULD ARRANGE TRANSPORTATION AND CARE DURING THE DAY.

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

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MEDICAL CONDITIONS THE SCHOOL NURSE SHOULD BE AWARE OF:

Asthma? Yes: ___ No: ___ Requires asthma medication? Yes: ___ No: ___ Name of asthma medication: _____

Severe Bee Sting Reaction? Yes: ___ No: ___ Requires an Epi-Pen? Yes: ___ No: ___

Peanut Allergy? Yes: ___ No: ___ Requires an Epi-Pen? Yes: ____ No: ____

Medication Allergies: _____ Other Allergies: _____

Medical or Emotional Conditions: _____

Medication student is currently taking: _____

Will the student require administration of prescription medication during the school day? Yes: ____ No: ____

Doctor's Name: _____ Phone#: _____ Dentist's Name: _____ Phone#: _____

*** PRESCRIPTION MEDICATION CANNOT BE GIVEN AT SCHOOL WITHOUT A PHYSICIAN'S ORDER AND THE COMPLETION OF APPROPRIATE FORMS (AVAILABLE IN THE NURSE'S OFFICE). This includes the use of Epi-Pens, Asthma Inhalers & Insulin. Controlled substances (i.e. narcotics, ADHD medication, etc.) MUST be delivered to the nurse by an adult. ALL medication must be brought directly to the nurse in the original and properly labeled container indicating the student's name, dosage, and time of administration.**

* COMPLETE AND SIGN BACK *

"The Lawrence County Career and Technical Center is an Equal Opportunity Employer"

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THE SCHOOL HEALTH OFFICE IS NOT A CLINIC, EMERGENCY ROOM, OR PHARMACY. Medication ordered by the school physician is for limited use. If your child has an illness or chronic condition, you MUST contact your personal physician for advice and care. The Health Office is for illnesses and injuries that occur <u>during</u> school, as well as treatments for students with chronic conditions as directed by their physician.

The following medications are available in the Health Office for <u>limited use</u>. If you check "Yes" below, you are giving the school nurse permission to administer the medication as ordered by the school physician. If you check "No" the medication will <u>NOT</u> be given.

Acetaminophen (Tylenol) Yes: ___ No: ___ Ibuprofen (Advil/Motrin) Yes: ___ No: ___ Emetrol (nausea) Yes: ___ No: ___

Antacid (Gelusil, Tums, Maalox, Mylanta) Yes: ___ No: ___ Benadryl (for mild allergic reactions) Yes: ___ No: ___

Immodium (diarrhea) Yes: ___ No: ___

* Cough drops are not supplied by the Health Office. Student may carry their own supply with a note from the parent.

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Pennsylvania Law (School Code XIV Section 1402) mandates that all **<u>eleventh grade</u>** students receive a medical physical examination. We encourage you to have your child examined by your family physician since he/she is most familiar with your child's physical health. However, you may choose to have your child examined by our school physician, Dr. Carlos Flores. This exam is free of charge and is only a screening. Your child will be referred to your family physician if a medical problem is identified. Please check your choice below.

_____ I will have my child's **<u>11th grade</u>** physical examination completed by our private family physician.

_____ I give permission for the school physician, Dr. Flores, to examine my child. I will be notified of the date.

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This form must be signed by the parent/guardian

Parent/Guardian Statement:

- By signing below, I give permission for the school nurse to administer medications as noted above.
- I agree to notify the nurse of any changes to my child's medical health.
- I give permission and understand that LCCTC may need to share my child's medical information with teaching staff, physicians, athletic trainers, coaches, school nurses, and other medical personnel. **<u>This will be on a need to know basis only, under HIPAA and FERRPA Laws.</u>** Any shared information will help to ensure the safety of your child and will remain strictly confidential.
- I give the LCCTC school nurse permission to contact our family physician/dentist concerning medical needs of my child (i.e. immunization status, changes to medical treatments provided during school hours). I also grant permission to my family physician/dentist to discuss this need with the LCCTC school nurse. I may rescind this in writing at any time.
- I hereby authorize LCCTC, in the event of an emergency, that is, when I am unable to be reached for authorization or when circumstances require immediate action, to proceed according to good medical practice with treatment of my child.

Parent/Guardian Signature: _____ Date: _____